R. I. COMMUNITY MENTAL HEALTH MEDICAID PROVIDER REFERENCE BOOK

R. I. DEPARTMENT OF MHRH
DIVISION OF BEHAVIORAL HEALTHCARE
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This Community Mental Health Medicaid Reference Book supersedes all existing versions of the Community Mental Health Medicaid Procedure Manual.

I. INTRODUCTION

The Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare (DBH), administers Community Mental Health Medicaid Services in Rhode Island in collaboration with the Department of Human Services (DHS). DHS is the single state agency for Medicaid and is responsible for the oversight and administration of the Medicaid program.

DHS and DBH have an inter-departmental agreement in place specifying the role that each agency plays in the operation of the program. Under this agreement, DHS is administratively responsible for processing payments; for ensuring that certified vendors are reimbursed for services provided to eligible clients; and in ensuring compliance with applicable state and federal Medicaid policies, rules and regulations. DBH handles the day-to-day operations of the program including negotiating fees; monitoring compliance with state and federal regulations and guidelines; recommending policies and procedures and ensuring compliance; and authorizing services where required.

II. FEDERAL AUTHORITY FOR SERVICE COVERAGE

Mental Health Medicaid Services are provided under the following Federal laws and/or regulations:

A. Section 440.130(d) of the Code of Federal Regulations (CFR), the "Rehabilitative Services Option", defined as follows:

Rehabilitative Services, except as otherwise provided under this sub-part, includes any medical or remedial services recommended by a physician or other Licensed Practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his highest possible functional level.

B. 42 CFR 440.167, "Personal Care Services", defined as follows:

(a) "Personal care services" means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, "family member" means a legally responsible relative.

III. CLIENT ELIGIBILITY

A. CATEGORIES OF ELIGIBILITY

In order to receive Community Mental Health Medicaid services, a client must be eligible for Medical Assistance coverage as either "categorically needy" or "medically needy only". Eligibility for the Rhode Island Medical Assistance Program can be confirmed by contacting the Recipient Eligibility Verification System (REVS) at the number shown in the Appendix.

B. INTENT TO FILE/RETROACTIVE ELIGIBILITY

Mental Health Medicaid provider agencies often provide services to clients for an extended period of time before they are able to gather enough information to generate an application for SSI, and for an even longer period before the client is actually approved. The mechanisms of "intent to file for SSI" and "retroactive eligibility for Medicaid" can be used to allow the agency to bill for services rendered prior to the actual date that the completed application, with all required documentation, is submitted to the SSI office.

Starting with "intent to file", SSI eligibility, with automatic concurrent Medicaid eligibility, is retroactive to either the date that the actual paperwork is filed with SSI or the date that the client provides SSI with notification of their intent to file for benefits. The "intent to file" must be in the form of a written statement indicating that the client intends to file for SSI and must be delivered to the same location as the actual paperwork. For purposes of Medicaid, the month of SSI eligibility becomes the first month of ongoing Medicaid eligibility.

Therefore, if you determine on May 29, for example, that a client is likely to be eligible for SSI, you should ensure that they deliver a written declaration of their intent to file to the appropriate SSI office on that same day. This will establish a "protected filing date" of May 29, even if the actual paperwork for the application isn't completed and turned into the SSI office until sometime in June.

With regard to "retroactive eligibility", clients may be eligible for Medicaid coverage (but not cash benefits) for the three months prior to the month of their application for SSI if they would have been determined eligible had they applied. That is, if a client has been at the same level of disability for four months and doesn't apply for SSI until the end of the fourth month, they can still potentially get Medicaid eligibility for the entire period assuming that all other Medicaid criteria are met.

While the application for this 3-month retroactive eligibility does not have to be made until after the basic SSI eligibility is established, it is best to handle it at the time of application. One of the questions on the SSI application form asks whether the client has any unpaid medical expenses during the three months prior to the month of application. (Using the May 29 protected filing date, that would mean bills for the period February 1–April 30.) Encourage the client to answer "yes" to this question if your agency has provided any services during that period. For practical purposes, you will probably want to limit attempts to claim retroactive eligibility to those clients who have used a substantial amount of service for which you have not been reimbursed.

As an example of how these two mechanisms can be used together, assume that you have a client who has consumed large amounts of crisis intervention and CPST time in each of the months of February, March, and April. Assume further that, on May 29, the CPST team meets with the client and determines that he is likely to be eligible for SSI. By giving SSI the client's intent to file on May 29, and indicating on the actual application when filed that the client has outstanding bills for each of the three months prior, you will have opened the window for potential Medicaid billing for all of the services provided during the period February 1–May 29 assuming that the client is eventually determined to be eligible.

While this does not solve the problem of occasional delays in the actual determination of SSI eligibility, it does give you the opportunity to eventually be reimbursed for services rendered.

C. MEDICALLY NEEDY CLIENTS AND THE "FLEX TEST"

1) General

States participating in the Medicaid program must provide Medicaid to categorical groups of individuals who are eligible to receive cash payments under one of the existing cash assistance programs established under the Social Security Act. In addition, states may also provide Medicaid to the medically needy and other categorical optional eligibility groups such as low-income aged and disabled individuals.

The "medically needy" group consists of those individuals who meet the categorical group requirements; have sufficient income to meet basic living expenses and, thus, are ineligible for a cash assistance program; but who have insufficient income to pay for medical expenses. Sections 1902(a)(17) and 1903(f)(2) of the Act provide that, for individuals applying as medically needy, certain incurred medical expenses must be deducted from income if income exceeds the eligibility standard established by the State. The process is commonly referred to as "spend-down" or the "flex test."

Eligibility for Medically Needy status is established when the applicant has presented a) receipts for medical services incurred during the period of determination and/or b) unpaid bills incurred whether during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income. These bills must be a) charged at the appropriate fee; b) be tied to specific services rendered; and c) not have been used before in determining eligibility. In the case of a provider under the Community Mental Health Medicaid Program, the "appropriate fee" is the amount that the provider would bill any other client in the same circumstances for the same identical service.

In general, the bill must be tied to specific services rendered and the provider must have appropriate documentation on hand to support the billing. Additionally, clients must have a legal liability for payment.

2) Utilization of RIACT Per Diem Bills

In order to make the process of dealing with the per diem billing methodologies utilized in dealing with RIACT teams more uniform, agencies must adhere to the following guidelines:

a) It is not necessary to submit a bill containing specific dates and times of the hours of face-to-face service provided to meet the minimum requirements. However, the bill must contain documentation that the required minimum hours indeed <u>were</u> provided and the date on which the required minimum was reached.

b) To ensure that all RIACT bills meet these requirements in a uniform manner, your bill must clearly contain the following language <u>exactly</u> as stated below:

> *(Enter Agency Name)* hereby certifies that *(Enter client name)* met the minimum service requirements necessary for per diem RIACT billing for the month of *(Enter month, year)* as specified in the Community Mental Health Medicaid Reference Book at the standard Medicaid fee on (*Enter date that required service hours were reached*).
>
> You are therefore liable for a bill for RIACT services in the amount of *(Enter amount in format $xxx.xx)*, accumulated over the period (*Enter date 1*) through (Enter *date 2*) at the rate of (*Enter applicable rate in format $yy.yy*) per diem. This amount may be used as proof of spend-down under Medicaid flex test requirements.

c) The bill must be submitted to the client. A copy may be submitted to DHS for Medicaid flex test purposes

d) The maximum allowable billing for RIACT services is set at an amount equal to the Medicaid fee that was in effect for the service on the day that the liability was incurred.

e) Community mental health agencies may <u>not</u> bill Medicaid the "amount due" on bills that are submitted to qualify for spend-down under the flex-test, as these bills are the legal liability of the client.

f) The client must be clearly liable for all bills used to meet the requirements of the Medicaid flex test and the agency must expend the same effort to collect those bills as it makes to collect any other client bill.

3) Utilization of Bills For CMAP Medications And Inpatient Services At Butler Hospital

Both the cost of medications provided to clients under the State's CMAP program and the cost of inpatient services provided in State beds at Butler Hospital may be used to reduce a Medical Assistance applicant's excess income under the following provisions taken directly from Section 0368.05 of the DHS Manual:

> Eligibility as Medically Needy is not established, however, until the applicant has presented
>
> 1) receipts for medical services incurred during the period of determination and/or;
>
> 2) unpaid bills incurred either during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income.
>
> The only exception is in the case of medical expenses that are paid by, or are the liability of, other medical care programs that are funded 100% with State funds. For example, an applicant's medical expenses that have been paid (or are to be paid) by the RIPAE or Rite Care programs are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spend-down liability.

The Department of Human Services provided DBH with an opinion on March 19, 1998 that CMAP medications fall under this exception as they are paid for with 100% State funds. In order to avoid any potential confusion at the DHS office, the bills generated for CMAP medications should be dated; have a dollar amount; and include a statement to the effect that "This medication was provided with 100% State funds". It would also be helpful if staff members and/or clients approaching DHS field office with this request were provided with the policy reference above.

Additionally, the Department of Human Services provided DBH with an opinion on July 12, 1999, that inpatient stays provided in State beds at Butler Hospital also fall under this exception as they are also paid for with 100% State funds. In order to avoid any potential confusion at the DHS office, the bills generated for inpatient episodes at Butler should be dated; have a dollar amount; and include a statement to the effect that: "This inpatient stay occurred in State beds which are paid for utilizing 100% state funds". It would also be helpful if staff members and/or clients approaching DHS field office with this request were provided with the policy reference above.

IV. PROVIDER ELIGIBILITY AND CERTIFICATION

In order to receive reimbursement from the Rhode Island Medical Assistance Program for the services outlined in this document, providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who:

1. Are licensed by the Rhode Island Department of Mental Health, Retardation and Hospitals and;
2. Are licensed for participation in the Rhode Island Medical Assistance Program by the Department of Human Services.

Agencies may be required to enter into a written agreement with DBH to establish eligibility for reimbursement for selected services.

All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations hereinafter referenced as "RR-BHO," as well as the procedures in this document and all other applicable state and local fire and safety codes and ordinances. Additionally, all programs under contract to DMHRH must meet all applicable contractual requirements as specified by the Department including, but not limited to, timely submission of all reports, data extracts, audits and plans of correction required by the Department. It is understood that these submissions might include individually identifiable Protected Health Information (PHI) in instances where the Department determines that it is required.

V. COVERED SERVICES

A. RESTRICTIONS APPLICABLE TO ALL SERVICES

The Rhode Island Medical Assistance Program will reimburse qualified providers for those medically necessary services provided to eligible recipients who meet the following criteria that are applicable to all services:

1) Service Authorization

In general, services are reimbursable only when provided in accordance with a treatment plan approved by a physician or other licensed practitioner of the healing arts.

For purposes of this program, a "licensed practitioner of the healing arts" is defined as a:

a) Physician;

b) Licensed Psychologist;

c) Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

d) Licensed Independent Social Worker (LISW) as defined in Rhode Island General Laws, Chapter 39;

e) Marriage and Family Therapist as licensed by the Rhode Island Department of Health;

f) Mental Health Counselor as licensed by the Rhode Island Department of Health.

Exclusions to this general rule include:

a) Crisis Intervention Services, which may be both recommended and delivered by the mental health professional on duty at the time of the crisis without the need for a treatment plan or approval by a licensed practitioner of the healing arts;

b) Multi-Disciplinary Treatment Planning;

c) Initial bio-psychosocial assessment which will serve as the basis for treatment plan development.

2) Service Setting

Providers are required to provide services in the setting that is most appropriate to the client's needs as prescribed in the treatment plan or, for crisis intervention services, wherever needed, and have the full authority and responsibility to do so.

3) Covered Diagnostic Categories*

At the current time, clients being treated for a primary diagnosable mental, behavioral, or emotional disorder that meets criteria of DSM-IV are eligible for services under the Community Mental Health Medicaid Program except that clients with any of the following primary diagnoses (see DSM-IV, pp. 15-24 for a listing by category) are excluded:

a) Any disorder characterized by "V" codes;

b) Any disorder listed in the section entitled "Substance Related Disorders" unless there is a concomitant primary mental, behavioral or emotional disorder not otherwise excluded in this procedure manual;

c) Any disorder listed under the sub-section entitled "Mental Retardation" unless here is a concomitant primary mental, behavioral or emotional disorder not

otherwise excluded in this procedure manual;

d) Any disorder listed under the section entitled "Impulse-Control Disorders Not Elsewhere Classified."

e) Axis II Anti-Social Personality Disorder (301.7)

Note that clients falling into classification 799.9, "Diagnosis Deferred On Axis I/II", are initially covered due to the extreme difficulty often involved in diagnosing certain categories of mental illness. Cases in which clients remain in this category for an extended period of time, or in which an agency has an unusually large number of clients in which the diagnosis is deferred, will be identified during the quality assurance and utilization review processes.

All questions with regard to which diagnosis codes might be considered permissible in addition to those listed above should be addressed to the Medicaid Project Officer at the address in the Appendix.

* The excluded diagnostic categories may be waived on a case-by-case basis by DBH for individuals who have had at least one admission lasting 180 days or more to the Adult Psychiatric Unit of Eleanor Slater Hospital or the former Institute of Mental Health. All applications for a waiver must be made in writing to the Medicaid Project Officer and contain a client history, including dates of hospitalization, as well as specific clinical and/or administrative justification for the request.

B. COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT (CPST)

1) Definition

Community Psychiatric Supportive Treatment (CPST) is a service provided to community-based clients and collaterals by mental health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure by monitoring and providing medically necessary interventions to assist them to manage the symptoms of their illness and deal with their overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. Services to be provided may include, but are not limited to, those delineated in the section of the RR-BHO dealing with Case Management and Community Psychiatric Supported Treatment.

2) General Program Guidelines

Reimbursable CPST services must be provided to clients who are 18 years of age or older; must be medically necessary and appropriate; must be specified and justified in the client's individual treatment plan; and must be properly documented. However, individuals classified as “General Outpatients” who receive CPST services must have their charts reviewed for reclassification as “Community Support” after every 30 individual days on which they receive a community-based CPST intervention. The results of this review must be clearly documented in the client record. If this documentation is accomplished through the use of progress notes, the treatment plan itself must refer the reviewer to said note(s).

3) Qualified Staff

Each staff member providing billable CPST interventions, or supervising the provision thereof, must meet the requirements of all applicable sections of the RR-BHO.

4) Reimbursement

a. Payments made for CPST interventions may not duplicate payments made by other program authorities for this same purpose. Billing for CPST interventions that are included and billed as an integral part of another provider service is prohibited. Additionally, billing under CPST for clients who are being served by a RIACT team and for whom a per-diem rate is being billed, is specifically prohibited.

b. Service time billed must be for direct, face-to-face contact with a client or collateral. Travel time and telephone time are not billable.

c. It is permissible to bill for CPST interventions provided to individuals in some hospitals under certain conditions. Specifically, if the client is in a hospital that is eligible to be reimbursed by Medicaid for their care, providers may bill for any CPST services that they provide for that individual as long as those services:

   1) Are specified in the client’s individual treatment plan;

   2) Are limited to the last 30 days before discharge from the hospital and;

   3) Do not duplicate the discharge planning activities required of the institution.

d. Reimbursement for CPST interventions will be made on a “unit-of-service” basis. . It is not permissible to add together several shorter visits to reach the minimum for a billable unit.

e. Reimbursement for CPST interventions may be requested for clients living in community residences for whom the provider is also billing under the MHPRR provisions outlined in this document in certain circumstances. Overall, it is expected that residents of MHPRRs will get their basic service package from the staff of the MHPRR. This would include the development of basic

social skills and support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized activities in the community. It is, however, expected that other specialty services, such as psychiatry and intensive psychiatric rehabilitation, will normally be provided outside of the setting of the residence by separate specialty staff.

Specifically, there are several model approaches to psychiatric rehabilitation that provide clients with intensive, individualized service in a community setting rather than dealing with them in a group approach such as that used in a traditional facility-based setting. The level of service provided by these programs is well beyond that which is required of the MHPRR staff. Therefore, services provided to MHPRR residents by staff members of these programs for the purposes of psychiatric rehabilitation are reimbursable under CPST provided that:

1. A member of a clearly defined psychiatric rehabilitation team performs the services on a 1:1 basis.

2. A maximum monthly average of 20% of the total CPST time billed for any given client may be for service provided in the MHPRR or in any other CMHC setting without prior approval of the Medicaid Project Officer. The remainder must be provided in a natural community setting.

3. The provider is not on the staff of any MHPRR for which Medicaid per diem reimbursement is being claimed;

4. The services do not duplicate the basic services that are required of MHPRR staff;

5. The services are clearly identifiable; adequately documented; specifically recommended in the treatment plan; and easily distinguished from the core services provided by MHPRR staff.

f. CPST interventions should be provided on an “as needed basis” with each individual getting the amount that is determined to be medically necessary. While there are no maximum caseload standards for reimbursement purposes, providers must meet any and all applicable program requirements contained in either state contracts or regulations.

g. There is a cap of an average of four (4) hours per day, calculated on a monthly basis, on reimbursement for CPST interventions. That is, the total hours billed for a given client in any calendar month cannot exceed the number of days that the client was in service during that month multiplied by four (4). Units provided in excess of the cap will not be reimbursed.

Additionally, clients for whom an agency bills CPST in excess of 10 hours/day for more than 2 consecutive days must have an immediate treatment plan review, appropriately documented in the medical record.

h. Some examples of CPST billing are as follows:

1. A staff member drives 1/2 hour to the client's home, spends 1/2 hour with the client, drives 1/2 hour back to the office and then spends 1/2 hour on the phone with the client's landlord. [Bill the equivalent of 1/2 hour of CPST as travel and phone time are already accounted for in the fee and are therefore not reimbursable as separate items.]

2. A staff member spends 1 hour with a client every Monday during the last 6 weeks of a client's hospitalization at a general hospital, working on issues that are specified in the individual’s individual treatment plan but which are not considered to be part of the hospital discharge team's responsibility. [Calculate 30 days back from the client's date of discharge and bill for any visits that fall within that time period. Billing for services provided outside of the 30-day time frame is prohibited.]

3. A staff member provides one hour of service to a group of 3 eligible recipients. [There is no fee for “group CPST”. You may either bill a single client for the entire time or divide

the time equally between the clients.]

4. A staff member, who is also a Registered Nurse drives 15 minutes to a client's home, takes approximately 40 minutes to provide both medication maintenance and CPST interventions, and then drives 15 minutes back to the office. [The travel time is not reimbursable. Billing for the remainder of the time depends on the amount of time that the nurse spends on each activity, i.e. medication and CPST. Assuming that he spends 20 minutes doing the medication and 20 minutes doing CPST, you would bill 20 minutes at the individual RN rate and 20 minutes at the CPST rate, both of which should be rounded to the appropriate billing unit.]

5. A community client who is not living in a licensed residential program was in service for the entire month of November and received a total of 125 hours of services during the month. [Multiply the number of days in the month (30) by the maximum allowable hours per day (4) to get the maximum billable hours per month (120). The remaining 5 hours are not billable.]

6. A resident of an MHPRR receives 10 hours of intensive, 1:1 psychiatric rehabilitation for the month of November, 2 hours of which takes place in the living room of the MHPRR, from a member of a clearly defined psychiatric rehabilitation team who is not on the staff of any MHPRR. [Bill the MHPRR rate for the month. In addition, bill for 10 hours of CPST, as the provision of this intensive, individualized psychiatric rehabilitation is not covered in the basic MHPRR fee. If the provision of service had been divided into 3 hours in the MHPRR and 7 hours in the community, only 9 hours would be billable as a maximum of 20% (2 hours, in this case) of total billings in a month can be in the MHPRR or other CMHC setting without prior written approval from the Medicaid Project Officer..]

C. PSYCHIATRIC REHABILITATION SERVICES

1) Definition

Psychiatric Rehabilitation Services are designed to help persons with behavioral health needs to optimize their personal and social competency in order to live successfully in the community. These services must conform to all of the applicable requirements of RR-BHO and must be determined to be medically necessary by specifying the need for the treatment in the client's individual treatment plan approved by a physician or other Licensed Practitioner of The Healing Arts as defined in this document:

2) Program Guidelines

a. The Structured Therapeutic component of the PRS may not be provided in a client's place of residence except in extenuating circumstances, and then only with prior written approval from DBH **.**

b. Psychiatric rehabilitation programs do not necessarily have to include a medication maintenance component but must provide access to same.

3) Qualified Staff

The overall psychiatric rehabilitation program must be staffed according to the requirements of the RR-BHO.

4) Reimbursement

a. A PRS visit must last a minimum of 60 minutes in order to bill. It is not permissible to aggregate several visits of less than one hour to make up the initial one-hour minimum. After meeting the minimum requirement, time spent face-to-face with the client during any single continuous contact over and above the initial 60 minutes may also be billed and should be rounded either up or down to the nearest 15-minute unit.

b. Basic educational services and services that are either strictly vocational or solely recreational in nature are not reimbursable.

c. You may bill for PRS services provided to individuals for whom you are billing MHPRR services as long as staff from any MHPRR are not also providing services at the PRS.

d. You may not bill for clients who are receiving RIACT services if those clients are being billed at a RIACT per diem subject to any exceptions granted during the process of bringing new teams on-line.

e. Some examples of PRS billing are as follows:

1. A client arrives at the Structured Therapeutic Program (STP) at 9 a.m. and leaves at 12:00 noon. [Bill for 3 hours of psychiatric rehabilitation utilizing the appropriate units as specified in the fee schedule.]

2. A client arrives at the STP at 9 a.m., leaves at 11 am for a one-hour therapy session with an MSW, returns at noon and leaves for the day at 1 p.m. [Bill for 3 hours of psychiatric rehabilitation utilizing the appropriate units as specified in the fee schedule. Also, bill for the MSW visit if it is recommended in the client's treatment plan.]

3. A client arrives at the Structured Therapeutic Program (STP) at 9 a.m. and leaves at 12:00 noon. The client returns to the STP from 2–4 p.m. and from 7–8:45 p.m. [Bill for 6 hours and 45 minutes of psychiatric rehabilitation (i.e. 27 15-minute units)]

D. CRISIS INTERVENTION SERVICES

1) Definition

Crisis Intervention Services are short-term emergency mental health services, available on a twenty-four hour basis, seven days a week. These services shall meet all of the applicable requirements of the RR-BHO.

2) Program Guidelines

a. Crisis intervention services are, by nature, of an emergency, non-routine nature. This service is not meant to be a substitute for aggressive outreach and CPST but should be used to respond on occasions when a client suffers an acute episode despite the provision of those services. It is permissible, however, to provide a maximum of three (3) crisis contacts immediately following the initial contact, provided that they are aimed at resolving the immediate crisis situation. Each of the three individual contacts is limited to a maximum of 8 reimbursable hours of service.

b. It is possible that an agency might use crisis intervention personnel in order to help alleviate a situation in which a waiting list precludes the immediate provision of routine services such as counseling and therapy or even as "central intake" for the agency as a whole. These services are not billable as "crisis intervention", even though crisis staff provides them. It is possible, however, that they might be billable under the "Clinician Services" section of the Community Mental Health Medicaid Program.

3) Qualified Staff

Each staff member providing billable Crisis intervention services, or supervising the provision thereof, must meet the requirements of all applicable sections of the RR-BHO.

4) Reimbursement

a. Billable crisis intervention services can include an emergency intake on a new client if that client is in crisis, but cannot include the routine intakes that occur when this service is also used as the central intake point for the provider.

b. Crisis intervention services delivered by telephone are not reimbursable. The need for extensive telephone work has been calculated into the overall fee structure.

c. A crisis worker can bill for only one eligible client at any given time. There is no provision for "group crisis intervention".

d. Crisis contacts must be performed by Emergency Service Clinicians in order to be billable. The designation of "emergency service clinician" can include an individual who has been assigned to be "on call" by the agency provided that the individual meets the minimum criteria specified in the RR-BHO.

In the event that an Emergency Service Clinician is not available and another qualified individual handles the contact, that individual may be eligible to bill under the Clinician Services section of this plan.

e. A minimum of 30 minutes may be billed for each use of this service regardless of the time actually spent.

f. Examples of proper billing for Crisis Intervention are as follows:

1. A crisis worker drives 15 minutes to the local YMCA spends 30 minutes evaluating an eligible individual and drives 15 minutes home. [Bill for the minimum 30 minutes of crisis intervention as travel time is not reimbursable.]

2. Under the same circumstances, the evaluation takes 45 minutes. [Bill for 45 minutes of

crisis intervention utilizing the appropriate units as specified in the fee schedule.]

3. The client's family brings him to the crisis unit. The worker spends 1/2 hour with the client, 1/2 hour with the family and then sends him home with the family temporarily until other housing can be arranged. The worker then spends two hours on the phone attempting to place the client in a more appropriate living situation. [Bill for one full hour. Crisis intervention nearly always involves working with a collateral or significant other to resolve the situation so the face-to-face contact with the family is billable. However, the follow-up telephone contacts are not.]

E. CLINICIAN SERVICES

1) Definition

"Clinician Services" are clinical diagnostic and treatment services to individuals with mental or emotional disorders, the individual's families, and others with significant ties to the clients.

These mental health services include, but are not limited to, assessment and evaluation; individual, family, couple, and group therapy; and medication treatment and review. With the exception of medication treatment and review, clinician services do not include those services that are part of another Community Mental Health Medicaid Service.

2) Program Guidelines

There is no arbitrary maximum placed on the overall number of clinician's visits that a client may receive in any given period of time nor is there any pre-authorization required. However, all visits must be medically necessary and appropriately documented.

3) Qualified Staff

Services provided by any of the following clinicians possessing a current license issued by the Rhode Island Department of Health are reimbursable:

a. Physician

b. Psychologist

c. Registered Nurse/Psychiatric Nurse

d. Licensed Clinical Social Worker (LCSW) or a Licensed Independent Clinical Social Worker (LICSW)

Clinicians who have not received the LCSW or LICSW accreditation but who hold a Master's Degree in clinical social work from a program that is accredited by the Council on Social Work Education and who are working towards achieving their LCSW/LICSW accreditation and are employed by a provider eligible under the Mental Health/Medicaid program will be reimbursable for a period not to exceed one year from the date on which they are hired. In rare instances, DBH may extend the one-year period upon receipt of written materials adequately documenting the reason for the request for an extension.

In order to ensure that adequate and appropriate care is provided to clients during that period, each employee qualifying under this exception must be supervised by a qualified professional staff member meeting the requirements for his or her profession as set forth in the RR-BHO. This supervision must conform to the guidelines set forth Section 8 of the RR-BHO.

Agencies must provide DBH with the names and hire dates of all clinicians that qualify under this exception process and must further notify the Project Officer at the time that the LCSW/LICSW designation is received. It is the responsibility of the agency to ensure that it only bills for eligible clinicians.

e. Psychiatric and Mental Health Nurse Clinical Specialist With Prescription Privileges;

A Psychiatric and Mental Health Nurse Clinical Specialist with Prescription Privileges shall have a Masters degree in nursing; a current R.I. license as a registered nurse; and certification as a "Psychiatric and Clinical Nurse Specialist" by the American Nurses Credentialing Center. Additionally, this individual must have current prescriptive privileges granted under the governance and supervision of the Rhode Island Department of Health, Division of Professional Regulation, Board of Nurse Registration and Nursing Education and operate in collaboration with a physician.

f. Mental Health Counselor

g. Marriage and Family Therapist;

Services provided by any of the following clinicians as certified by the Rhode Certification Board for Chemical Dependency Professionals and licensed by the State of Rhode Island, Department of Mental Health, Retardation and Hospitals are reimbursable:

a. Licensed Chemical Dependency Professional

b. Licensed Chemical Dependency Supervisor

Services provided by any of the following clinicians as certified by the State of Rhode Island, Department of Mental Health, Retardation and Hospitals are reimbursable:

a. Principal Counselor

A Principal Counselor shall have at least a Master's degree from an accredited program* in counseling or clinical psychology and the equivalent of two years of full-time supervised clinical experience in a mental health setting and be certified by DBH. Standards for certification are available from DBH.

b. Counselor

A Counselor shall have at least a Master's degree from an accredited program* in counseling or clinical psychology and the equivalent of one year of full-time supervised clinical experience in a mental health setting and be certified by DBH. Standards for certification are available from DBH.

A Counselor must be supervised until the equivalent of a total of two years of experience is earned. This supervision must be provided by a qualified professional staff member meeting the requirements for his or her profession as set forth in the RR-BHO. This supervision must conform to the guidelines set forth Section 8 of the RR-BHO.

* An “accredited program” must be accredited by the New England Association of Schools and Colleges, or an equivalent regional accrediting agency, and must have the approval of a recognized national or regional certifying authority. Examples of acceptable programs are the Master's in Rehabilitation Counseling offered by RIC, BU and Assumption, the Master's in Agency Counseling offered by RIC, and the Master's in Marriage and Family Therapy offered by URI.

4) Reimbursement

a. Medication treatment and review is reimbursable only when provided by a physician or registered nurse.

b. In cases where more than one member of the family receives counseling, reimbursement depends on which family member is being treated for a mental disorder according to a treatment plan and also on who is Medicaid eligible. (In most cases, an entire family would be eligible.) As a general rule, agencies should use the service code that matches the client whose treatment plan is being addressed by the service.

For example, if the child has a mental disorder and the child's treatment plan calls for counseling of the parents in order to treat the disorder, the clinician's visit with the parents would most likely be billable under the child's record. Therefore, if a social worker saw the child for 15 minutes and the mother for 15 minutes consecutively, the agency should bill the service out as a single visit of the appropriate length against the child’s coverage. The treatment notes would document who was actually seen and the services provided.

Alternatively, assume in the above example that the mother also has a mental disorder and her own individual treatment plan and it was her disorder and that was being treated in the second session. In that case, the agency should bill two individual visits of the appropriate length, provided that both the mother and child were Medicaid eligible.

Note that group therapy billing codes should not be used for family therapy, but only for services rendered to groups of unrelated clients, all of who have their own individual treatment plans.

c. In general, clients should not get more than a single one-and-one-half (1.5) hour assessment every six months in conjunction with their treatment plan review. Where sudden changes in symptoms require an additional assessment, the clinical necessity for the assessment should be fully documented in the client's case record.

d. All medically related duties performed for eligible clients by Registered Nurses are reimbursable providing that those services are prescribed in the client's individual plan of care. That is, the portion of a nurse's duties in which they meet with individual clients to monitor and record physical vital signs; administer any type of prescription medication; discuss new or ongoing physical problems; monitor the effects of psychotropic medications prescribed by a physician; or supervise the provision of recommended services, are all reimbursable.

   Additionally, the portion of the nurse's duties in which they work to educate individual clients in the areas of medication, nutrition, exercise, etc. are reimbursable when these activities are prescribed as an integral part of the overall treatment regimen in the client's individual treatment plan.

e. The portion of any clinician's duties in which they offer consultation to other staff in the agency or act as a liaison between staff and community medical personnel is not reimbursable under coverage for “clinician's services”. However, the liaison portion of this type of activity may be consistent with the services provided by a Community Support Professional and, depending on the specific circumstances, may therefore be billable as CPST.

f. Individuals billing under the LCDP/LCDS classification may be reimbursed only for chemical dependency assessment and counseling services provided to clients who carry both a primary diagnosis of mental illness and a clear secondary diagnosis of substance abuse. Both diagnoses must be clearly visible in the client’s individual record and the chemical dependency services must be clearly specified in the client’s treatment plan.

F. MENTAL HEALTH PSYCHIATRIC REHABILITATIVE RESIDENCE

1) Definition

A Mental Health Psychiatric Rehabilitative Residence (MHPRR) is a licensed residential program with no more than sixteen (16) beds which provides 24-hour staffing in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services.

Specific services may include, but are not limited to, those services delineated in section 38 of the RR-BHO.

2) Exclusions

a. Any programs or services provided to residents that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking residents with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, programs geared towards developing appropriate behaviors for operating in an overall social or work environment are reimbursable. An example of a non-reimbursable service would be one in which a resident is taught to cook with the intent of securing a job in a restaurant. An example of a reimbursable service would be one in which a client learns to cook as an integral part of an overall rehabilitation program designed to teach the client how to plan nutritious meals; budget money; shop; perform tasks according to a schedule and under a deadline; develop sequential thinking skills; and interact with other individuals in a cooperative, task-oriented effort.

3) Provider Certification

Providers must be certified by DBH before they can bill for MHPRR services. This certification is in addition to any other requirement for participation in the Mental Health Medicaid Program.

In order to be certified, each Provider must submit an “Application for Provider Certification-MHPRR” (see Appendix) along with the following items to DBH:

a. A copy of a current license issued by MHRH to operate each individual residential program for which certification is desired.

b. A copy of a current variance from MHRH if the program has more than 12 beds.

c. A signed and dated copy of the “Service Agreement: Mental Health Psychiatric Rehabilitative Residence” (see Appendix).

d. Once certified, an agency may continue to bill for an unlimited period of time assuming that it is in compliance with all applicable regulations and standards. .

4) Service Authorization

MHPRR services must be authorized by appropriate personnel as specified in the RR-BHO.

5) Medical Records/Treatment Planning

Medical records must comply with the overall Medical Record Documentation Guidelines contained in the RR-BHO as well as with any applicable guidelines in this document.

6) Reimbursement

a. The MHPRR rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program. This would include basic social skills development and support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized activities in their community.

As these costs do not include the cost of psychiatry, providers may be reimbursed separately for any physician's services provided. Additionally, providers may be reimbursed for nursing activities (medication administration, counseling, diet management, etc.) as long as the nurse is not on the staff of any MHPRR for which Medicaid reimbursement is being claimed. Providers may also be reimbursed for any other non-residence based services provided to the client such as psychiatric rehabilitation or CMHC-based counseling and therapy, as long as they are not provided by staff of any MHPRR for which Medicaid reimbursement is being claimed.

b. Reimbursement for CPST interventions is also available on a unit-of-service basis for residents for whom MHPRR is being billed under certain circumstances.

Specifically, there are several model approaches to psychiatric rehabilitation that provide clients with intensive, individualized service in a community setting rather than dealing with them in a group approach such as that used in a traditional “psych rehab” setting. The level of service provided by these programs is well beyond that which is required of the MHPRR staff either under the “Skill Assessment and Development” section of the MHPRR service description or under state contract. Therefore, services provided to MHPRR residents by staff members of these programs for the purposes of psychiatric rehabilitation are reimbursable under CPST provided that:

1. A member of a clearly defined psychiatric rehabilitation team performs the services on a 1:1 basis;
2. A maximum monthly average of 20% of the total CPST time billed for any given client may be for service provided in the MHPRR or in any other CMHC setting without the prior written approval of the Medicaid Project Officer. The remainder must be provided in a natural community setting;
3. The provider is not on the staff of any MHPRR for which Medicaid reimbursement is being claimed;
4. The services do not duplicate the basic services that are required of MHPRR staff;
5. The services are clearly identifiable; adequately documented; specifically recommended in the treatment plan; and easily distinguished from the core services provided by MHPRR staff.

However, you may not claim separate reimbursement for:

1. RIACT services, regardless of who provides them or the amount provided;
2. Crisis intervention, unless provided by a physician;
3. Counseling or therapy provided either in the residence or by the staff of any MHPRR except as specified in section V.F.6.a of this document.

c. You may claim MHPRR reimbursement for days on which clients who are residents of the MHPRR are temporarily absent for 5 consecutive days or less for reasons other than hospitalization (e.g. home visit, etc.) as long as they return to the residence within 30 days. You may not claim reimbursement for days over 5 or in situations in which the client does not return within 30 days of the date of departure.

d. When clients are hospitalized, the following restrictions apply:

1. If the client is in Butler Hospital or any other facility classified as an IMD (Institution for

Mental Disease) you may not bill Medicaid for services that you provide regardless of what those services are.

2. If the client is in any hospital that is being reimbursed by Medicaid for their care, you may not bill the MHPRR per diem rate. You may, however, be eligible to bill CPST on a unit-of-service basis for services that you provide to that individual as long as those services are:

   a) Limited to the last 30 days before discharge from the hospital and;

   b) Will not duplicate the discharge planning activities required of the institution.

e You may bill for both the day of admission to, and the day of discharge from, the MHPRR.

f. Examples of billing for MHPRR are as follows:

1. A client lives in the MHPRR for the entire month of October although he went home on Friday and Saturday night one weekend. [Bill for 31 days of MHPRR per diem.]

2. A client lives in the MHPRR for the entire month of October although he went home on Friday and Saturday night one weekend. This client also received one-on-one services from a Community Support Professional as a part of his intensive psychiatric rehabilitation program for three hours in the afternoon on four consecutive Thursdays at the local community center. Additionally, the client required the services of a crisis intervention team for two hours one night. [Bill for 31 days of MHPRR per diem. If a physician provided the crisis intervention service, bill separately for those two hours. If a physician did not provide it, the hours are not billable. Also, bill for the 12 hours of CPST as it is part of an intensive, individualized psychiatric rehabilitation program that is above the level of service normally expected of residential programs.]

3. Jack Smith lived in the MHPRR from August 1 through August 15. He was then discharged to the CMHC's Independent Apartment Program where he received basic CPST services for the remainder of the month. [Bill for 15 days of MHPRR service on a per diem basis as service should be counted from the day of admission through the day of discharge. As Jack was discharged from the residence on August 15, you should bill separately for any CPST services provided after that date using the appropriate forms and procedures for CPST billing.]

G. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT I

1) Definition

A Rhode Island Assertive Community Treatment I (RIACT-I) team is a self-contained program that is the fixed point of responsibility for providing the treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness. Specific program requirements and services are delineated in the RR-BHO.

2) Exclusions

a. Any programs or services provided to clients that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking clients with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, support activities and activities directly related to assisting a client to cope with his mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment are reimbursable. An example of a reimbursable service would be one in which a team member spends time at the client's place of employment assisting the client to work out problems with his supervisor or co-workers brought about as a result of his mental illness.

3) Certification

a. Rhode Island Assertive Community Treatment I programs shall be surveyed by the Department for compliance with the appropriate sections of the RR-BHO prior to being authorized to bill Medicaid. After the initial survey, programs will be monitored during the State's periodic licensing visits.

b. RIACT-I programs must operate in accordance with the RR-BHO with the following exception:

Section 35.2.1.A states that a client shall be discharged from RIACT-I when the client moves out of the geographic area of responsibility. However, Medicaid requirements relating to state-wideness and freedom-of-choice do not allow for termination of service based on geographic area alone.

For purposes of Medicaid billing, a client may be discharged when they move out of the area in which the team is capable of providing service. In such cases, the RIACT team shall arrange for the transfer of mental health service responsibility to a provider who is capable of providing service in the location to which the client is moving, either in RI or out of state. The RIACT team shall maintain contact with the client until the client completes the intake process and services have been established.

4) Reimbursement

a. It is anticipated that RIACT-I staff will provide the bulk of the everyday services required by the clients served by the team. Therefore, providers are prohibited from billing the Mental Health Medicaid Program for any costs over and above the RIACT-I per diem with the following exceptions:

1. It is permissible to bill for <u>infrequent</u> Crisis Intervention Services provided by CMHC Emergency Services staff, as long as all of the appropriate requirements are met.

2. It is permissible to bill separately for any services above and beyond the normal levels of RIACT-I service provision that are specifically required to maintain an individual on

clozapine.

3. It is permissible to bill separately for up to 5 total hours of physician and/or R.N. time spread over a period of 15 calendar days for the initial screening intake; physician intake; and induction phase of treatment for clients being started on Buprenorphine. This additional billing is restricted to 5 hours total per client, to be provided in a single 15-day period not more often than once every two calendar years.

There are no circumstances other than those listed above in which any provider may bill the Community Mental Health Medicaid program separately for any other covered service for a RIACT-I client who is being billed under the per diem method.

b. In the event that services are provided and billed under one of the "exception" categories listed above, the service time may not be counted towards the minimum RIACT-I contact hours required for per diem RIACT-I billing. That is, in the event that RIACT-I staff accompanies the client to a program billable under an "exception category", agencies may count either the RIACT-I contact hours or bill for the program services provided but may not do both.

c. There are occasions on which RIACT-I staff might conduct group activities that also involve individuals who are not RIACT-I clients but who are eligible for Medicaid. If the clinician is a full-time RIACT-I staff member, it is not permissible to bill Medicaid separately for services provided to the clients who are not enrolled in the RIACT-I program.

If the clinician is a part-time RIACT-I staff member, you may EITHER a) bill Medicaid separately for services provided to the non-RIACT-I clients in the group setting OR b) count the group time as contact time for the RIACT-I clients. You may not, however, do both.

d. You may not bill RIACT-I per diem rates for hospitalized clients regardless of the circumstances of the hospitalization. You may, however, be able to bill unit-based CPST for services that meet the standards in Section V of this document.

e. RIACT-1 was conceived and costed out as an individual service model. In the event that a clinician provides a service to a group of RIACT-1 clients, the clinician's time must be pro-rated across the members of the group. As an example, if a clinician provides one hour of service to a group of 4 clients, each client would receive 15 minutes of contact time.

f. The RR-BHO require that each client receive at least 1 hour of service each week within a total of at least eight hours of services per month. In order to operationalize this for Medicaid billing purposes, please apply the guidelines, which are based on a monthly billing cycle, contained in the following chart. The service hours required should be adjusted downward to reflect instances in which an individual is in RIACT-I for less than the full month (e.g. 2 hours are required for a client in the program for 1 week, 4 hours are required for a client in the program for 2 weeks, etc.)

Monthly Service Hours	Billing Procedures	
8 or more		Bill as indicated in the "Billing Instructions: RIACT-I" (i.e. per diem)
5.0--7.9	First Month	Bill as indicated in the "Billing Instructions: RIACT-I" (i.e. per diem) but include clinical justification for the reduced service level in the client's individual case record.
	Three or More Months	For a client who receives less than 8 hours, but at least 5 hours, for three or more consecutive months, bill the first two months as instructed above (i.e. per diem). The third month must be billed at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation. (E.g. Bill the community-based CPST rate if the practitioner is an MSW providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)
< 5.0		Bill at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation. (i.e. bill the CPST rate if the practitioner is an MSW providing CPST; the MSW rate if the practitioner is an MSW doing therapy; etc.)

H. SPECIALIZED MENTAL HEALTH CONSULTATION TO NURSING FACILITIES

1) Definition

Specialized Mental Health Consultation to Nursing Facilities is a service designed to allow NFs to access expert clinical psycho-geriatric consultation from Community Mental Health Centers on psychiatric and/or behavioral concerns designed to impact both on an individual case and, by logical extension, on the operation of the NF as a whole. Typical concerns may be related to, but are not limited to, depression (e.g. sad mood, poor self-esteem, suicidal thoughts, apathy, crying, unremitting grief, lack of interest in activities and environment, weight loss, sleep disturbance and fatigue); dementia (e.g. confusion, thievery and increasing memory problems); and behavioral problems (e.g. demanding of staff attention, agitation, wandering, yelling and verbal and physical abuse of staff and/or other residents).

2) General Program Guidelines

a) Concerns/behaviors leading to a request for this service must be of such severity as to require a level of expertise beyond that which the NF would normally be expected to provide and must not duplicate services covered under the facility's basic rate.

b) All consultation must be face-to-face, either with the professional staff of the NF or with the resident who is the subject of the consultation. Telephone contacts are not billable regardless of their length.

c) "Specialized Mental Health Consultation To Nursing Facilities" is separate and distinct from the ongoing treatment services that are generally provided by the facility and may not be used either as a substitute for, or a supplement to, same. Consultation is limited to assisting the professional staff of the NF in the diagnosis, assessment and overall handling of difficult, complex cases that have not responded to standard approaches. As a part of this process, it is strongly recommended that the consultant conduct periodic examinations of the resident as required in order to assist in specifying or altering the course of treatment.

d) Each consultation may be provided only at the written request of the facility with the originator of the request being limited to the client's physician of record; a staff mental health professional (e.g. social worker, psychologist, etc.); the Director of Nursing; or the facility administrator. The request must document the medical necessity of the consult and clearly delineate that the service requested is beyond that which the NF would normally provide. CMHCs may respond to phone requests on an emergency basis provided that written back up follows within 7 calendar days.

e) Both the original request and the result of the consultation must be documented with proper signatures in the resident's individual case record maintained at the facility. A copy of both the original request and the result of the consultation must also be provided to the consultant and filed in such a manner as to provide a clear audit trail at the CMHC between the facility's request; the actual provision of consultation; the documentation of same; and the submission of a bill to Medicaid.

f) Each resident is entitled to twelve (12) consults at a maximum duration of four (4) hours/consult per calendar year or episode in a single NF, whichever is shorter, without prior authorization. Consults in excess of twelve (12) require prior authorization from the Medicaid Project Officer, DBH.

g) It is strongly recommended, but not required, that the facility attempt to reduce the need to use this service by assuring that consultation is provided to all staff dealing with the type of case in question with an emphasis placed on the generalizability of the knowledge transmitted. That is, each individual case should be seen as an opportunity to broaden the knowledge base of key NF staff members so as to enhance their ability to deal with future difficult cases within their own resource base.

3) Qualified Staff

Staff members providing consultation must be either a physician, a Registered Nurse, or an LICSW and must have specialized expertise in the provision of mental health services to the elderly.

4) Reimbursement

a) Payments made for Specialized Mental Health Consultation to Nursing Facilities may not duplicate payments for service made under other program authorities. Specifically, this service must be separate and distinct from those services covered under the overall Medicaid facility rate paid to the NF.

b) It is not permissible to bill for a “group consultation”. Each consultation must be billed individually.

c) Court testimony is not billable under this coverage.

d) Each consultation must last for a minimum of 30 minutes for each individual case, exclusive of travel time, in order to be billable. Consultation provided on multiple cases at the same facility on the same day may be billed provided that a minimum of 30 minutes is spent on each individual case.

e) Some examples of SMHCNF billing are as follows:

1. A Registered Nurse drives 25 minutes to a NF, spends 30 minutes assessing the client; an additional 20 minutes consulting with the social worker and a nurse's aide; and then drives 25 minutes back to the center. [Bill for a total of 50 minutes of RN time following the guidelines in the fee schedule as the travel time is not reimbursable]

2. A physician spends 30 minutes on the phone with a social worker at a NF discussing the details of a case. [Do not bill as phone time is not billable.]

3. An Elderly Specialist/MSW travels 25 minutes to a NF that is experiencing difficulty in dealing with 3 Medicaid eligible residents who are physically abusive to both staff and other residents. The MSW selects one specific case and uses it as the basis of a one-hour meeting for all staff members that deal with the clients, instructing them in specific behavioral interventions that have proven to be effective in the past and that are viewed as state-of-the-art. As a part of the meeting, participants actually engage in role-playing scenarios designed to enhance their skills in dealing with this type of situation effectively without additional outside consultation. The MSW then travels 25 minutes back to the CMHC. [Bill for one hour of SMHCNF following the guidelines in the fee schedule as travel time is not billable. The use of a single client's situation as a “case study” to help enhance worker's skills in dealing with an overall type of patient is strongly encouraged.]

I. MULTI-DISCIPLINARY MENTAL HEALTH TREATMENT PLANNING

1) Definition

Multi-Disciplinary Mental Health Treatment Planning is the formulation, maintenance, monitoring and modification of an individualized treatment plan by a multi-disciplinary team in conjunction with the client whenever possible.

2) Qualified Staff

Staff must meet the requirements of the RR-BHO.

3) Program Guidelines

a) Treatment plans billed under this coverage must must be developed and maintained in compliance with the overall requirements of the RR-BHO, as well as conforming to any other service-specific documentation requirements.

b) Each individual client is restricted to a maximum of six (6) billable hours of service under this coverage per calendar year.

c) All aspects of the treatment planning process may be billed under this coverage including, but not limited to, the development of the initial plan; formulation of the comprehensive master plan; routine reviews; reviews necessitated by a significant change in the client's condition; reviews required at the end of the estimated length of treatment; and discharge or termination planning. Additionally, the development of a sub-plan in a specialty area under the overall plan (e.g. the formulation of a specific, detailed rehabilitation-oriented component of the plan) is considered to be a billable component.

4) Reimbursement

a) A billable unit requires the participation of a minimum 3-member team, not including the physician, for the entire session. The team must include at least one Licensed Practitioner of The Healing Arts as specified in this manual.

The documentation for this service must include a mechanism by which Medicaid can easily confirm that the minimum number of professionals participated during each unit billed. Additionally, it must show clear evidence of physician participation in those sessions for which the higher “with physician” fee is billed. The simplest way to handle this would be to have at least 3 of the team members, including at least one Licensed Practitioner of the Healing Arts and the physician, if present, sign the plan.

b) All reviews billed under this coverage must be documented in the client’s individual medical record either as an addendum/amendment to the treatment plan; in a progress note; or by utilizing an alternative, agency-specific method that complies with the requirements of the RR-BHO.

Regardless of the method chosen, evidence of the MDTP session, complete with all required signatures, must either appear somewhere in its entirety in the medical record or the record must note that the MDTP took place and clearly direct the reviewer to a specific location where complete documentation can be easily found.

c) It is <u>not</u> permissible to bill under this coverage for clients who are also being billed under RIACT as both of these programs are self-contained services that include comprehensive treatment planning in their overall fee structure.

d) It <u>is</u> permissible to bill under this coverage for clients who are also being billed under MHPRR coverage, provided that at least two of the team members, not including the physician, are not on staff of any MHPRR for which the agency is billing Medicaid.

J. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT II (RIACT-II)

1) Definition

A Rhode Island Assertive Community Treatment II (RIACT-II) team is a self-contained program that is the fixed point of responsibility for providing the treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness. Clientele are those with mental illness who, while not experiencing functional impairment of the degree of severity which would require the service intensity offered by a Rhode Island Assertive Community Treatment I, nevertheless require a complex, coordinated array of services. Specific program requirements and services are as delineated in the RR-BHO.

2) Exclusions

a. Any programs or services provided to clients that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking clients with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, support activities and activities directly related to assisting a client to cope with his mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment are reimbursable. An example of a reimbursable service would be one in which a team member spends time at the client's place of employment assisting the client to solve interpersonal problems with his supervisor or co-workers brought about as a result of his mental illness.

3) Certification

a. Rhode Island Assertive Community Treatment I programs shall be surveyed by the Department for compliance with the appropriate sections of the RR-BHO prior to being authorized to bill Medicaid. At the discretion of the Department, waivers of any and all requirements may be permitted during the start-up period for a new team. After the initial survey, programs will be monitored during the State's periodic licensing visits.

b. RIACT-II programs must operate in accordance with the RR-BHO except that any language specifying discharge when the client moves out of the geographic area of responsibility shall not apply due to Medicaid requirements relating to state-wideness and freedom-of-choice which do not allow for termination of service based on geographic area alone.

For purposes of Medicaid billing, a client may be discharged when they move out of the area in which the team is capable of providing service. In such cases, the RIACT team shall arrange for the transfer of mental health service responsibility to a provider who is capable of providing service in the location to which the client is moving, either in RI or out of state. The RIACT team shall maintain contact with the client until the client completes the intake process and services have been established.

4) Reimbursement

a. It is expected that RIACT-II staff will provide the bulk of the everyday services required by the clients served by the team. Therefore, providers are prohibited from billing the Mental Health Medicaid Program for any costs over and above the RIACT-II per diem with the following exceptions:

1. It is permissible to bill for <u>infrequent</u> Crisis Intervention Services provided by CMHC Emergency Services staff, as long as all of the appropriate requirements are met.

2. It is permissible to bill separately for any services above and beyond the normal levels of RIACT-II service provision that are specifically required to maintain an individual on Clozaril.

3. Each consumer's experience of mental illness is unique and is accompanied by complex psychological issues. In order to maintain continuity of care, all new admissions to the team may be allowed to complete any current course of time-limited, disorder-specific therapy for up to 12 visits after admission. This therapy must have begun prior to team admission, with RIACT-II progress notes tracking progress and integrating the care provided in this therapeutic relationship with RIACT-II efforts.

4. While the team should have the capacity to provide the vast majority of individual supportive therapy required by its clients, there may be unique disorders that need to be treated but do not occur often enough in the RIACT-II population to justify the team's adding that specific capacity (e.g. eating disorders). In these rare instances, the team may refer the client to appropriate, disorder-specific specialized therapy. The clinical record must contain clear documentation substantiating these referrals and must also comprehensively address the integration of team and specialty treatment

5. Many of the clients who will be eligible for RIACT-II are currently enrolled in Psychiatric Rehabilitation Programs that often provide an overall structure for their lives. While DBH anticipates that provider agencies will develop viable alternatives within, or as an adjunct to, the RIACT-II program, it is also aware that abrupt movement to a new service modality can be disruptive to the therapeutic process. Therefore, in order to allow for a smooth and orderly transition to the new service modality, providers will be allowed to continue to bill for Structured Therapeutic Units provided to RIACT-II clients after they begin to bill the RIACT-II per diem for a period of up to 3-months (90 days)/client.

6. It is permissible to bill separately for up to 5 total hours of physician and/or R.N. time spread over a period of 15 calendar days for the initial screening intake; physician intake; and induction phase of treatment for clients being started on Buprenorphine. This additional billing is restricted to 5 hours total per client, to be provided in a single 15-day period not more often than once every two calendar years.

7. Many of the clients who will be eligible for RIACT-II are currently enrolled in RIACT-I programs. In order to provide for an effective transition from both the clinical and fiscal viewpoints, providers will be allowed to bill the RIACT-1 fee for clients who drop to the RIACT-2 care level for 30 days after the client is transferred, providing that RIACT-2 minimum hourly requirements are met.

There are no circumstances other than those listed above in which any provider may bill the Community Mental Health Medicaid program separately for any other covered service including, but not limited to, physicians services, nursing services, psychiatric rehabilitation, psychotherapy, substance abuse treatment, CPST, etc., for any RIACT-II client who is being billed under the per diem method.

b. In the event that services are provided and billed under one of the "exception" categories listed above, the service time itself may not be counted towards the minimum RIACT-II contact hours required for per diem RIACT-II billing. That is, in the event that a RIACT-II staff member accompanies the client to a program billable under an "exception category", agencies may count either the RIACT-II contact hours or bill for the program services provided but may not do both.

c. There are occasions on which RIACT-II staff might conduct group activities that also involve individuals who are not RIACT-II clients but who are eligible for Medicaid. If the clinician is a full-time RIACT-II staff member, it is not permissible to bill Medicaid separately for services provided to the clients who are not enrolled in RIACT-II.

If the clinician is a part-time RIACT-II staff member, you may EITHER a) bill Medicaid separately for services provided to the non-RIACT-II clients in the group setting OR b) count the

group time pro-rated as contact time for the RIACT-II clients. You may not do both.

d. You may not bill RIACT-II per diem rates for hospitalized clients regardless of the circumstances of the hospitalization. You might, however, be able to bill unit-based CPST for services that meet the standards in Section V of this manual.

e. RIACT-II was conceived and costed out as an individual service model. In the event that a clinician provides a service to a group of RIACT-II clients, the clinician's time must be pro-rated across the members of the group. As an example, if a clinician provides one hour of service to a group of 4 clients, each client would receive 15 minutes of contact time.

f. The RIACT-II Standards require that an average of 4 hours of face-to-face service per month be provided to a client or collateral in order for that client to be considered as a RIACT-II client. In order to operationalize this for Medicaid billing purposes, please apply the guidelines contained in the following chart, which are based on a monthly billing cycle. The service hours required should be adjusted downward to reflect instances in which an individual is served by the RIACT-II team for less than the full month (e.g. 1 hour is required for a client in the program for 1 week, 2 hours are required for a client in the program for 2 weeks, etc.)

Monthly Service Hours	RIACT-II Billing Procedures	
4 or more		Bill as indicated in the "Billing Instructions: RIACT-II" (i.e. per diem)
2.5--3.9	First Month	Bill as indicated in the "Billing Instructions: RIACT-II" (i.e. per diem) but include clinical justification for the reduced service level in the client's individual case record.
	Three or More Months	For a client who receives less than 4 hours, but at least 2.5 hours, for three or more consecutive months, bill the first two months as instructed above (i.e. per diem). The third month must be billed at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation (i.e. Bill the community-based CPST rate if the practitioner is a caseworker providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)
<2.5		Bill at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation (i.e. Bill the community-based CPST rate if the practitioner is a caseworker providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)

VI. GENERAL REQUIREMENTS AND LIMITATIONS FOR ALL SERVICES

A. All services listed must comply with the service authorization requirements contained in section V.A. of this document.

B. Providers may only bill for the clinician actually providing the service. For example, if a Registered Nurse who is supervised by a physician sees a client, the agency can only bill for the RN unless the physician was physically present and participating in the service provision. The agency may not, however, bill for two clinicians providing a service to the client at the same time other than in the special circumstances described in the section of this manual dealing with Multi-Disciplinary Treatment Planning.

C. Claims for clients with a primary alcohol or drug diagnosis, without an accompanying primary mental health diagnosis, will be denied unless they fall under the waiver provisions of Section V(A)(3) of this document. However, if a client with a primary psychiatric diagnosis has a secondary diagnosis of substance abuse and the secondary problem is treated during the course of therapy for the primary psychiatric diagnosis, the portion of service related to the secondary problem is billable.

D. Each client's individual treatment plan must, at a minimum, meet the requirements of all applicable sections of the RR-BHO

E. The Department of Human Services requires providers to maintain professional control in a manner that will ensure reasonable and proper utilization of medical services and supplies.

F. Providers must utilize all other third party resources, such as Federal Medicare, Blue Cross/Blue Shield or other private health or casualty insurance coverage, when available, prior to billing the Medical Assistance Program. For example, if a client has Medicare, you must bill Medicare first for all services that it covers. Specific billing instructions can be found in the Rehabilitative Services Provider Reference Manual available from the Department of Human Services or on the web at http://www.dhs.state.ri.us .

G. There are no restrictions against eligible clients receiving several reimbursable services from the RI Medical Assistance Program except where specifically prohibited in this manual. For example, while the manual specifically prohibits providers from billing for RIACT-I services while also billing for MHPRR, there are no prohibitions against an MHPRR resident receiving Adult Day Care services from another entity provided that the services are medically necessary and do not duplicate the services required of the MHPRR. Additional services might include, for example, the full range of services provided for physical illness, home health aides, adult day care, visiting nurses, etc.

Contact the Medicaid Project Officer listed in the Appendix of this document with questions regarding this policy.

H. Staff for each program must meet all applicable requirements of the RR-BHO.

VII. BILLING

A. GENERAL PROCEDURES

All billing must be done in accordance with Medicaid guidelines which are available from the Department Of Human Services or on the web at http://www.dhs.state.ri.us .

B. SPECIFIC BILLING INSTRUCTIONS

1. Collateral Contacts

Providers may bill for collateral contacts. A collateral contact is a contact made on behalf of the client with someone other than the client, such as a family member, landlord, personnel at another social service agency, or other person with significant ties to the client. However, “case consultation” provided to other agencies, or to other professionals in the same agency, is not billable as a collateral contact, nor are telephone contacts of any type.

2. Multiple Services in One Day

There is no general restriction against billing for multiple services provided to the same client in a single day provided that they are medically necessary and stay within the guidelines for individual services set forth in this manual.

There is, however, a general prohibition against billing for two or more services simultaneously. As an example, an agency may not bill for a unit of psychiatric rehabilitation and a unit of counseling occurring at the same time. It would, however, be allowable to bill for a unit of psychiatric rehabilitation immediately followed by a unit of counseling.

VIII. DOCUMENTATION REQUIREMENTS

A. Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to Medical Assistance recipients and to furnish to the State Medicaid Agency, the State Mental Health Authority, and/or the Medicaid Fraud and Abuse Unit of the Attorney General's Office such records and any other information regarding payments claimed or services rendered as may be requested.

B. A clear audit trail must be maintained. Each provider is responsible for devising a system that documents all services provided. This back-up information is usually contained in the clinical record, daily attendance logs, or both. It must be sufficiently detailed to show, for example, that a client was in a day program for the number of hours for which Medicaid was billed for this service on any given day. Documentation of this nature must be retained by the agency, must adhere to the document retention policies of the Department of Human Services and the Department of MHRH; and must be promptly provided to the State or its authorized agents upon request. In the event that the policies differ with regard to the length of time that records must be retained, the policy requiring retention for the longest period of time shall apply.

C. All services billed must be authorized in accordance with section V.A. of this document.

D. All entries in the client's individual plan of care shall be signed and dated by the individual who performed the service, as well as by any other required signatory, in the time frame contained in the RR-BHO.

E. Written treatment or progress notes must comply with all requirements of the RRS-BHO.

F. The “treatment plan” section of the medical record is regarded by Medicaid as the overall prescription for services to be provided and acts as the primary source of authorization for Medicaid payment for services delivered. Therefore, it is important to ensure that the plan is kept current and meets all requirements for signatures as specified in the RR-BHO..

G. The agency must clearly document any deviation from the services specified in the treatment plan. In the event that the deviations result in the client receiving services in excess of those recommended in the plan, this documentation must provide adequate information for Department staff to assess whether or not those services were appropriate and medically necessary. In the event that the deviations result in the client receiving less service than recommended in the treatment plan, the documentation must provide adequate information for reviewers to assess whether the client subsequently received appropriate outreach and follow-up, if necessary.

H. At the time of their 6-month treatment plan review, all Community Support Clients for whom you are billing Medicaid must:

a) have the “staff” portion of the Rhode Island Outcome Evaluation Instrument (OEI) fully completed and submitted to DBH by the end of the calendar month following the month in which the review was due and;

b) be given the opportunity to complete and submit the “client” portion of the OEI at that same time.

I. The following program-specific guidelines also apply:

1) <u>Community Psychiatric Supportive Treatment (Unit-of-Service)</u>

Written treatment or progress notes shall be maintained for CPST clients in one of the following formats:

a. Minimal contact notes, weekly and monthly summaries.

In this format, each individual contact with the client must be documented as follows at a minimum:

1. Client's name, unless evident;

2. Clinician’s name, unless evident;

3. Place of visit (e.g. home, provider site, etc.);

4. Type of visit (e.g. group, individual, etc.);

5. Service provided (e.g. coordinating medical services, assistance with income maintenance, etc.);

6. Date, time (unless kept elsewhere) and duration of service (e.g. 9/9/1999, 10:00-11:00 a.m.; 9/9/1999, 10 a.m., 1 hour; etc.).

This information can be entered onto a coded sheet with no narrative required for the individual notes. However, weekly and monthly summaries of the overall relationship of the services to the treatment regimen described in the treatment plan are required and must conform to all applicable requirements of the RR-BHO. The weekly summary for the last week of the month can also be incorporated into the monthly summary.

Note also that significant events and/or significant changes in the client's condition should be documented with a full narrative note whenever they occur.

b. Complete contact notes.

A complete progress note conforming to the requirements of the RR-BHO is entered for each individual contact. In this format, weekly and monthly summaries are not required.

2) Clinician Services and Crisis Intervention

A separate entry is required for each individual service billed under Clinician Services or Crisis Intervention. This entry shall include, at a minimum, all of the elements contained in the RR-BHO.

3) Psychiatric Rehabilitation Services

Written treatment or progress notes for psychiatric rehabilitation services may take the form of a monthly summary of the overall relationship of the services provided to the treatment regimen prescribed in the treatment plan provided that a) they conform to all applicable requirements of the RR-BHO and b) full back-up documentation, such as attendance reports or sign-in sheets, is readily available.

Alternatively, a complete progress note conforming to the requirements of the RR-BHO may be entered for each individual contact. In this format, weekly and monthly summaries are not required.

A separate progress note that meets all requirements of the RR-BHO is required whenever clients receive a medication maintenance visit as part of their psychiatric rehabilitation program.

IX. MONITORING AND QUALITY ASSURANCE

The overall Utilization Review and Quality Assurance activities of MHRH and the Department of Human Services as authorized by the CFR are as follows:

A) Implement a statewide community mental health services surveillance and utilization control program that:

1. Safeguards against unnecessary or inappropriate use of community mental health services and against excess payments;
2. Assesses the quality of community mental health services;
3. Provides for control of utilization of Medicaid services (CFR 456.3).

B) Establish and use written criteria for evaluating the appropriateness and quality of Medicaid services (CFR 456.5).

C) Establish a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services (CFR 456.6).

D) Provide for the ongoing evaluation of the need for, and timeliness of, community mental health services on a sample basis (CFR 456.22).

E) Conduct a post-payment review process that allows state personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria. The process must identify exceptions so that the state agency can correct improper utilization practices of recipients and providers (CFR 456.23).

In order to operationalize these requirements, DMHRH staff will conduct periodic site visits at each agency to monitor appropriate use of Medicaid services and compliance with the policies and procedures in this document. During these visits, staff will review client records and treatment plans as well as internal policies and procedures relating to Medicaid service provision, billing and documentation as appropriate.

Unannounced site visits may also be conducted at any location at which Medicaid services are being billed if determined to be necessary by Department. All Medicaid services are subject to review during these visits.

Adverse findings from the site visits will be dealt with in a manner to be determined by MHRH, in consultation with DHS.

In addition to routine monitoring conducted by MHRH and DHS, providers are subject to periodic fiscal and program audits by the Centers for Medicare and Medicaid Services.

Appendix 1: Sample MHPRR Service Agreement

Service Agreement: Mental Health Psychiatric Rehabilitative Residence
Rhode Island Department of Mental Health, Retardation and Hospitals

Provider Name: _____

Provider Address: _____

Provider FID #: _____

For purposes of being certified by the Division of Behavioral Healthcare to provide MHPRR services and to bill for these services under the Mental Health Medicaid Program, (provider name)_____, hereinafter referred to as the Provider, certifies that:

1. The name, location and bed capacity of the program(s) to be billed is as follows:

Program Name	Program Location	Beds

The Provider will not submit MHPRR bills for residents in any program other than those listed above.

2. The Provider will meet all requirements of the current standard "Provider Agreement" for the Mental Health Medicaid Program.

3. The Provider will adhere to all regulations, policies, procedures and/or guidelines regarding service provision, documentation and billing disseminated by the Department of Mental Heatlh, Rehabilitation and Hospitals; the Division of Behavioral Healthcare; or the Department of Human Services or their agents.

4. The Provider will inform the Medicaid Project Officer, Division of Behavioral Healthcare, if the residence becomes unlicensed for any reason and will cease Medicaid billing immediately pending resolution.

Authorized Signature: _____

Date: _____

PRR-SA 04/22/05

Appendix 2: Sample MHPRR Provider Certification Application

Application for Provider Certification
Mental Health Psychiatric Rehabilitative Residence
Rhode Island Department of Mental Health, Retardation and Hospitals

(Provider Name)_____ hereby applies for certification as a provider of Mental Health Psychiatric Rehabilitative Residence services.

We have enclosed the following:

_____ 1. A copy of a current license issued by MHRH to operate each individual rehabilitative residence program for which certification is desired. (The Provider is responsible for ensuring that the Division of Behavioral Healthcare has a copy of a current license for the residence on file at all times.)

_____ 2. A copy of a current variance for the operation of any rehabilitative residence of more than 12 beds for which certification is desired.

_____ 3. A single, signed and dated copy of the "Service Agreement: Mental Health Psychiatric Rehabilitative Residence".

Signature: _____

Date: _____

Return completed application to the Medicaid Project Officer,
Division of Behavioral Healthcare
Department of Mental Health, Retardation and Hospitals
Incomplete applications will not be processed.

PRR-CA
07/14/06

Appendix 3: Medical Record Documentation Guidelines

Please refer to the "**Rules and Regulations for the Licensing of Behavioral Healthcare Organizations**" promulgated by the RI Department of Mental Health, Retardation and Hospitals for specific guidance regarding the content of medical records.

Appendix 4: Contact List

MEDICAID PROJECT OFFICER, DIVISION OF BEHAVIORAL HEALTHCARE:

Barry Hall 3rd Floor
14 Harrington Road
Cranston, RI 02920
Phone 401-462-1714 FAX 401-462-0339

STATE MEDICAID AGENCY:

Liaison–Clients Under 21Years of Age:

Beth O'Reilly, Case Manager
Center For Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-462-6351

Liaison–Clients 21Years of Age and Over:

Paula Avarista
Center For Adult Health
Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-462-2183

Recipient Eligibility Hotline:

1-800-347-3322 (8:20 A.M.--6:30 P.M. Mon--Fri)

RIteCare Hotline:

1-800-346-1004

FISCAL AGENT:

Electronic Data Systems (EDS)
1471 Elmwood Avenue
Cranston, RI 02910

Help Desk: 401-784-8100 (local to Cranston)
1-800-964-6211 (outside Cranston area)

REVS Line: 1-800-964-6211 (24 hours for provider calls only)

HEALTH DEPARTMENT:

Division of Professional Regulation: 222-2827

07/12/06

Appendix 5: Commonly Asked Questions and Answers

COMMONLY ASKED QUESTIONS AND ANSWERS ABOUT COMMUNITY MENTAL HEALTH MEDICAID COVERAGE

Q1. What is a "Licensed Practitioner of the Healing Arts?"

A1. The listing of specific disciplines included under the title of "Licensed Practitioner" may be changed periodically. Please refer to the "Covered Services" section of this document for the most recent definition.

Q2. Does a Psychiatric Rehabilitation Program have to include a Medication Maintenance component?

A2. No, it does not. However, if it does, agencies should have a tracking system in place that clearly separates out and documents those hours during which a client receives a medication visit.

Q3. Are we subject to audit or review by agencies other than the Department of Mental Health, Retardation, & Hospitals?

A3. Yes. You are subject to fiscal and program audits by the Centers For Medicare and Medicaid Services (CMS) and by the Rhode Island Department of Human Services (DHS). Additionally, you may also be subject to review by the Fraud and Abuse Unit of the Office of the Attorney General.

Q4. Does a medical doctor have to authorize service by signing the treatment plan?

A4. In general, a treatment plan may be signed by any Licensed Practitioner of the Healing Arts as defined in the "Covered Services" section of this document unless there are more stringent requirements on a specific service in the RR-BHO. Keep in mind that all treatment plan reviews carry with them the same authorization requirements as the original plan. That is, they must also be signed by the appropriate professional within the specified time frame.

Q5. For purposes of billing Medicaid, does the time of day, duration and physical setting of the service have to be included in the actual clinical record to document services? Must these items be included in the treatment or progress notes?

A5. While it would be convenient to have all of this information contained in one spot in the clinical record for the purposes of an audit, it is not required. However, if it is not contained in the clinical record, it must be recorded in such a manner as to make it readily accessible to an auditor. This requirement might be met by recording the information on monthly service cards and then adding the cards to the client's clinical record at the end of each month. Alternatively, the information could be collected on service tickets and than entered and maintained on computer until a printout is required provided that the source documents (service tickets) are also available as back-up.

Q6. Can service information recorded on the computer take the place of a progress note?

A6. No, unless the provider is using a DMHRH-approved system of computerized medical records that

meet the requirements of the RR-BHO. Otherwise, there must be a dated progress or treatment note in the client's clinical record for each service billed to Medicaid unless otherwise specified in this document. For example, there are specific allowable mechanisms for billing for MHPRR and CPST services that do not require a note for each individual contact.

Q7. Is a chart indicating which medications were given by which clinician sufficient documentation to justify a medication visit with a nurse or physician?

A7. No. There must be a progress note for each service rendered. In the course of a typical 15-20 minute outpatient medication visit, a clinician does more than simply administer medication. . For example, the clinician might ascertain whether the medication is having the desired effect on the client's psychiatric condition; check for signs of adverse side effects; gather input on the client's overall progress, etc. The progress note must fully describe the service and should include the clinician's observations as well as the administration of the medication.

Q8. What is the definition of a collateral contract?

A8. A contact made on behalf of the client with a "collateral" as defined in the RR-BHO. In practice, this would normally be someone such as a family member, landlord, personnel at another social service agency, or another person with significant ties to the client. However, "Case Consultation" provided to other agencies or to other professionals in the same agency is not billable as a collateral contact. Be aware that you can bill only for face-to-face contacts and not for phone calls.

Q9. Does an "assessment" have to be face-to-face or can it be a "paper" review of the case?

A9. An assessment must meet the requirements for a "Bio-Psychosocial Assessment" as defined by the RR-BHO and must involve face-to-face contact in order to be billable.

Q10. How is MHPRR billing affected if the client goes home for a weekend visit?

A10. You should continue to bill for the client. The weekend visit is a part of the client's treatment and the MHPRR staff serves as the back up in the event of an emergency.

Q11. Why do GOP clients require a chart review for transfer to CSP status after every 30 days of CPST service?

A11. We found via a survey of the system that only 0.5% of GOP clients were projected to need more than 30 hours of CPST on an annual basis. Given the rarity of this occurrence, we determined that it is reasonable to place a requirement for closer scrutiny on cases of this nature. In this instance, that consists of a mandatory review of the case for potential transfer to CSP status.

Q12. Why is there a limit of 4 hours per day on CPST and what happens if my client needs 6 hours of service one day and none the next?

A12. The limit is not set at "4 hours per day" but at "an <u>average</u> of 4 hours per day calculated on a monthly basis". Thus, if client A is in service for the entire month of December, he is eligible to

receive up to a total of 124 hours of service during the month (31 days multiplied by 4 hours per day). This might be provided at the rate of 4 hours a day for 31 days; 8 hours a day for 15 days and 4 hours on 1 day; etc. Remember that provision of more than 10 hours of CPST per day for 2 consecutive days must trigger an immediate treatment plan review.

Q13. We determined that the hospital to which we send our client's does not bill Medicaid for any physician's visits. Can we therefore bill for the time that our psychiatrist spends at the hospital with our clients?

A13. If the psychiatrist's visits are for services by the attending physician, they can be billed as any other attending physician would bill. If they are not attending physician services, they would have to meet the requirements outlined in the CPST section of this manual and be billed according to the fee schedule for CPST.

Q14. We sometimes take clients into our program who have been released to the community from an IMD for several days on a "trial" basis. Can we bill Medicaid for these services?

A14. Possibly, depending on the client's age. 42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. If a patient is released to a community setting for a trial visit, this is "convalescent leave." If the patient is released on the condition that they receive outpatient treatment or on other comparable conditions, the patient is on conditional release. If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services could be covered under Medicaid because the individual is not considered an IMD patient during these periods.

However, the regulation contains a separate provision for individuals under age 22 who have been receiving inpatient psychiatric services under 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he is unconditionally released or the date that he reaches age 22, whichever comes first.

Q15. We spend a lot of time when an RIACT client is hospitalized in State beds at Butler working towards their discharge. If we can't bill Medicaid for this time due to the IMD prohibition, can we at least count these hours towards the client's monthly RIACT service minimum?

A15. MHRH realizes that hospitalization of a client, whether it be in the psychiatric unit of a general hospital or in an IMD, is a serious matter and that all of the team's resources need to be brought to bear. This can involve extensive face-to-face contact with both the client and collaterals, all of which may be counted towards the minimum monthly hours required, providing that those contacts do not duplicate the services that the hospital is required to provide.

Q16. We spend a lot of time when a RIACT client is incarcerated at the ACI or hospitalized at the ESH Forensic Unit trying to get things set up for their discharge. Can we bill Medicaid for these days?

A16. No. You may not bill RIACT for days that clients spend in a public institution. However, as is the case for clients who are hospitalized in an IMD, involvement in the criminal justice system is a serious matter that may require a major expenditure of resources on the part of the team. Any face-

to-face contact with either the client or collaterals while they are these settings may be counted towards the minimum monthly hours required for RIACT per diem billing. For example, if a RIACT-I client spends December 1-5 at the ACI and the team spends 8 hours over that period working with the client and/or collaterals in order to achieve a smooth transition back into the community, you may count that time towards any monthly minimum requirements for billing purposes.

Q17. Our center has many cases in which the client is only seen by a physician. Given the comprehensive nature of the physician's follow-up notes, is a treatment plan review necessary as frequently as is specified in the RR-BHO? Additionally, do we actually have to re-write these plans in their entirety every 12 months?

A17: All treatment plan reviews and rewrites must conform to the requirements in the RR-BHO.

Q18. A client in our MHPRR suffered a broken arm, is in a cast, and needs assistance in bathing. Are we required to provide this?

A18. The provision of limited physical assistance is covered in the RR-BHO. In this specific instance, we would expect that MHPRR staff would assist the resident in covering the cast with a waterproof material and assist them in and out of the shower if required. We would also expect that you would also help them with cutting their food, getting dressed, etc.

However, we realize that MHPRRs are staffed primarily to handle the mental health care needs of their clients and not to handle residents with heavy physical care needs on an ongoing basis. For example, staff would not be expected to actually change diapers in the case of incontinent clients or to deal with oxygen in the case of clients with respiratory conditions.

Clients with ongoing conditions that require extensive physical care should be carefully assessed for relocation to a facility that is appropriately staffed. Alternatively, procurement of the services of a home health aide or personal care attendant might be explored with the State Medicaid Agency.

Q19. Should the OEI be included in the client's individual medical record?

A19. The completed survey itself need not necessarily become a part of the client's medical record. In fact, we recommend that the portions of the survey dealing with the client's opinion of services not be stored in a location that is accessible to the individual clinician.

Q20. Is it necessary to document in the medical record that the client was given the opportunity to complete the OEI?

A20. Documentation in the medical record is only necessary in cases in which the client both refuses to complete the OEI and refuses to put the uncompleted OEI in the envelope, sign the seal, and return it to staff. In all other cases, receipt of the instrument by MHRH, whether complete or incomplete, will be considered to meet the requirement of giving the client the "opportunity to complete".

Q21. How do you judge compliance with the "6 month treatment plan review" requirement?

A21. A plan shall be judged to be in compliance with the "6-month review" requirement if it is reviewed within 30 days of the end of the calendar month during which the "sixth month of treatment" occurs. For example, a treatment plan written on either January 1 or January 31 would be due for a review by July 31 but would be found in compliance with the review requirement if it was completed by August 30. That same plan would still be due for a complete re-write on January 31. Once again, however, the 30-day window will allow the agency until March 2 to complete the re-write.

THE FOLLOWING QUESTIONS RELATE TO RIACT-2 IMPLEMENTATION

Q22. Do we have to use the RIACT-1 biopsychosocial instrument (i.e. CAT) and protocol for RIACT-2 clients?

A22. No, you do not. You may use your existing assessment format and protocol provided that they comply with the requirements of the Rules and Regulations for the licensing of Behavioral Healthcare Organizations (RR-BHO).

Q23. Will we need to provide 24 hour back up coverage in the event of a holiday?

A23. Basic after-hours and holiday coverage for RIACT-2 may be handled by the agency's emergency services unit. However, a member of the RIACT-2 team must be available to the ESU for phone consultation in the event that the issue requires a more detailed understanding of the client and their situation. This individual must be a member of the team and not simply someone else in the agency who is familiar with the clients and/or program.

Q24. Does the team still have to operate for 6 days during a week with a holiday?

A24. No. The '6-day/week' rule does not apply to weeks that contain a holiday.

Q25. Can a staff person who is actively pursing their Counselor-In-Training (CIT) certification and being supervised by an LCDP supervisor fill the role of the SA specialist?

A25. Yes, for a period of up to 4 years from their hire date at the program, as long as the individual continues to actively pursue their CIT. It is the responsibility of the agency to monitor the staff member's progress and to make appropriate arrangements in the event that they do not complete their training on schedule.

Q26. You indicate in RR-BHO 36.14 that the 'team leader or designee' must conduct an initial assessment and develop a 60 day treatment plan. Must the 'designee' be a part of the team or can it be a clinician from elsewhere in the agency?

A26. The 'designee' must either be a part of the RIACT-2 team or be slated to become a member of the team within 60 days after the assessment is completed. The emphasis on an integrated team approach would be compromised by allowing a non-team member to complete assessments and treatment plans.

Q27. Does at least one of the rehabilitation specialists have to have a Master's degree?

A27. No. However, if none of them have a Master's, they must be supervised by a senior rehabilitation staff person (MA level) as stated in 36.5.5 of the RR-BHO. The focus of this supervision should be on the vocational work being done by the specialists on the team.

Q28. How do we receive appropriate credit for group sessions?

A28. Although RIACT-2 is both based and costed out on an individual services model, we realize that the provision of group therapy is sometimes both cost-effective and clinically appropriate. In order to operationalize billing for this modality, divide the total time by the number of clients in the group and count that amount towards each client's monthly service time. That is, if there is group with six RIACT-2 clients that lasts for 60 minutes, each client would be assigned 10 minutes of monthly contact time.

Q29. Can we get waivers of requirements during the start up period?

A29. During the start-up period for each team, we will consider making 'temporary accommodations' on an individual basis in the area of staffing as well as in other areas as long as the clinical integrity of the team and client care are not compromised.

Q30. Will we be subject to RIACT-2 specific audits and/or other reviews prior to our next licensing visit?

A30. Yes. DBH will need to monitor RIACT-2 closely during start-up to insure that programs are in compliance with all requirements and that it is performing as planned. Monitoring requirements will include the submission of RIACT-specific monthly reports detailing census and staffing along with periodic technical assistance visits from DBH staff.

Additionally, at the direction of DHS, DBH will be putting in place a system under which it reviews a randomly selected set of paid claims to insure that appropriate supporting documentation is on file in case records and other agency logs. These reviews may be conducted by DBH personnel, the SURS unit, or a combination of both.

Q31. May we use a RN-CNS with prescribing privileges to handle medications? If so, may we count their time towards the monthly requirement for psychiatry?

A31. It is acceptable to use a properly credentialed and supervised RN-CNS with prescribing privileges to take on some of the burden of the psychiatrist for medication-related activities. This time can comprise up to 25% of the monthly psychiatric time called for by the RR-BHO but may not substitute for any specific requirements for client contact with a psychiatrist. For example, the RN-CNS would not be able to replace the psychiatrist at the initial client interview.

Q32. How do we handle billing for specialized services such as eating disorders, DBT or psychiatric rehabilitation?

A32. Looking first at psychiatric rehabilitation, providers are allowed to continue to bill for psychiatric

rehabilitation services for a period of up to three months from the date that a client is admitted to the RIACT-2 program. After that initial period, it is expected that the provision of any required psychiatric rehabilitation will be covered in the base payment for RIACT-2.

With regard to other specialized therapies such as DBT or those dealing with eating disorders, the RR-BHO allows for the team to refer a client out for disorder-specific therapy in 'rare instances'. The referrals must be both clearly documented in the client record and integrated into the client's overall treatment regimen. They may also be singled out for an extended review by DBH and, depending on their frequency, may be considered for prior authorization.

Q33. Will there be an allowance for current staff (ie. therapist, caseworker, psychiatrist, etc.) to continue to service a transitioned RIACT-2 client?

A33. Yes, in some circumstances. DBH realizes that each consumer's experience with mental illness is unique and is accompanied by complex psychological issues. In order to maintain continuity of care, all new admissions to the team may be allowed to complete any current course of disorder-specific therapy for up to 12 visits after admission. The progress made in this therapy must be tracked in RIACT-2 progress notes and clearly demonstrate the integration of care provided in this therapeutic relationship with RIACT-2 efforts.

However, this allowance does not extend to the client's prior caseworker.

Q34. What is the process for implementing billing starting a RIACT-2 team?

A34. The agency must submit a detailed work plan to DBH laying out a clear timeline for start-up. This work plan must address staffing considerations; client transition from RIACT-1; eventual team size; and plans to address all requirements in the area of assessments, treatment plans, and other paperwork.

Upon approval, DBH will send the agency a letter authorizing them to begin to both provide and bill for services. At the same time, DBH will contact DHS to authorize payment for the team.

We anticipate that members of the DBH monitoring team will work closely with each agency in the initial 60-90 days to insure a smooth start up.

Q35. Many of our clients are referred to ORS. Can the work that we do under the cooperative agreement also be part of the contact hours that the vocational worker counts for RIACT-2? Can work with ORS services be part of the contact hours done by the vocational worker and also allow for the per diem tier payments provided in the cooperative agreement?

A35. Provider agencies may refer any adult client on their caseload to ORS without regard for client type, e.g. GOP, CSP, RIACT-1/RIACT-2, etc. In point of fact, we encourage providers to take advantage of ORS offerings for any client who might benefit from the wide range of vocational services that they have available.

However, providers may not bill ORS under the DMHRH/ORS cooperative agreement for clients for whom you are billing RIACT-1/RIACT-2 to Medicaid.

Q36. Section 135.8 states that RIACT-2 staff are expected to handle all crisis calls during program

operational hours. For purposes of billing, at what point does MHRH see the crisis intervention responsibilities of a RIACT-02 team ending and ES beginning ?

A36. The agency's core ES function may come into play outside of the program's operational hours provided that there is a RIACT-2 team member assigned to be reachable via phone in the event that additional information about the client is needed. Additionally, it is understandable that the ES unit may be called upon for those infrequent occasions during operational hours when an emergency arises while all staff are already engaged with other clients.

Q37. We would like to run groups including a mix of both regular CSP and RIACT-2 clients and plan to have these groups co-facilitated by a RIACT-2 staff member and a CSP clinician. How would we bill for this?

A37. There is currently no mechanism to bill for 'co-facilitated' groups. Therefore, you may either take the time provided by the RIACT-2 clinician, divide it by the overall number of clients in the group, and apply that to each RIACT-2 client's monthly service hours or use the appropriate billing mechanism to bill for the non-RIACT clients.

Q38. Are there new billing codes? If so, how will we find out what they are and get the specifics of billing?

A38. DHS/EDS will contact each approved provider or RIACT-2 services on an individual basis and work through coding and billing.

Q39. Who do we call if we have questions?

A39. It depends on the question. Questions regarding specific procedural items in this document should be directed to the Medicaid Project Officer, Division of Behavioral Healthcare, MHRH. All billing questions should be directed to EDS. If you're not satisfied with the response that you get from either of the above, contact the DHS liaison. Phone numbers for contacts are in the Appendix.